March 27, 2020

David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

RE: Health Policy Commission's Public Hearing on the Potential Modification of the 2021 Health Care Cost Growth Benchmark

Dear Director Seltz:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 member health plans that provide coverage to nearly 3 million Massachusetts residents, I am writing in response to the Health Policy Commission's Hearing on the Potential Modification of the 2021 Health Care Cost Growth Benchmark. We appreciate the Commission engaging with stakeholders to seek input and the opportunity to offer our comments in support of maintaining the 2021 Health Care Cost Growth Benchmark at 3.1 percent.

As the Center for Health Information and Analysis's (CHIA) *Performance of the Massachusetts Health Care System Annual Report 2019* report noted, Massachusetts' health care costs are beginning to grow at an accelerated rate as compared to years past.[1] In 2018, Total Health Care Expenditures (THCE) in Massachusetts reached $60.9 billion, with THCE per capita growing by 3.1%, matching the benchmark set by the Health Policy Commission for 2018. With spending growth increasing at a faster rate in 2018 for the largest service categories than in past years, the health care cost growth benchmark remains a vital guardrail for monitoring performance in the health care sector and setting priorities for addressing costs.

While the growth in Massachusetts health care spending has been lower than the increase in national health care expenditures, the state's health care costs remain among the highest in the nation and rising health care costs continue to pose a significant challenge for employers and consumers. As premiums reflect the cost of care, holding all entities accountable to a strong cost growth benchmark and addressing health care cost drivers are essential to making health care affordable for our state's residents. While significant effort has been undertaken to meet the cost benchmark, there is still work to be done to improve the affordability and quality of health care, and we must not take our focus away from our mission to control health care costs.

[1] http://www.chiamass.gov/assets/2019-annual-report/2019-Annual-Report.pdf

Keeping the benchmark at 3.1% requires accountability across the entire health care system. We urge the Commission to consider the following priorities in monitoring performance against the benchmark as means to ensure whole-system accountability:

Accountability Under the Benchmark: Prescription Drug Manufacturers & Hospitals

Prescription drug spending remains an enormous challenge for Massachusetts employers and consumers, with pharmacy costs continuing to outpace costs in all other spending categories, accounting for 26.4% of increased spending, a whopping 16.3% of total health care spending, and nearly 25% of commercial spending in 2018 according to CHIA's *Performance of the Massachusetts Health Care System Annual Report 2019*. Furthermore, the Health Policy Commission (HPC), in its *2019 Health Care Costs Trends Report,* noted that prescription drug spending grew by 5.8% in 2018 or by 3.6% net of rebates, continuing a multi-year trend of pharmacy spending growth threatening the state's cost benchmark.

This growth in prescription drug costs is not unique to Massachusetts. In 2018, the Centers for Medicare and Medicaid (CMS) found that prescription drug spending nationally grew by 2.5% to account for $335 billion in national health expenditures, faster than the 1.4% rate of growth in 2017.[2] Between 2020 and 2027, CMS projects that prescription drug spending will grow by 6.1% **per year** on average.[3] While pharmaceutical manufacturers have argued that price increases for prescription drugs do not take into account rebates negotiated by pharmacy benefit managers or health plans, a March 2020 JAMA study highlights persistent and pervasive prescription drug cost growth, even when taking rebates into account. In the study, researchers found that from 2007 to 2018, list prices on 602 medications rose by 159% and, after accounting for rebates and discounts, net prices for the same drugs increased by 60%. The analysis found the greatest increase in both list prices and net prices for multiple sclerosis treatments, 439% and 157% respectively, cholesterol medicines, 278% and 95% respectively, and for medicines used to treat rheumatoid arthritis, 166% and 73% respectively.[4]

As the Commission considers performance against the benchmark, it is critical that pharmaceutical manufacturers are required to justify these high prices being charged for new and existing drugs and be held accountable to the benchmark. Health plans and providers have been accountable to meeting the state's cost growth benchmark, but pharmaceutical manufacturers have notably been missing from the list of required witnesses at the annual Cost Trends Hearing and the associated data collection requirements by the HPC, CHIA, and the state's Attorney General. This lack of representation has allowed years of unchecked cost growth for prescription drug manufacturers, threatening the state's ability to meet the benchmark and bend the cost curve.

We, therefore, strongly support the HPC's recommendation from the *2019 Cost Trends Report* that "policymakers take action to increase oversight transparency for the full drug distribution chain, including (1) authorizing the expansion of the HPC's review to drugs with a financial impact to the commercial market in Massachusetts, (2) imposing a penalty on manufacturers that increase the price of a drug above an inflation-based threshold level, … and, (4) requiring manufacturers and

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

[4] Hernandez I, San-Juan-Rodriguez A, Good CB, Gellad WF. Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018. JAMA. 2020;323(9):854–862. doi:10.1001/jama.2020.1012

[pharmacy benefit managers] to participate in the HPC's annual cost trends hearing and report data for inclusion in CHIA's and the HPC's annual reports on health care cost drivers."

Expanding the HPC's review to drugs with a financial impact to the commercial market in Massachusetts is necessary to truly understand the impact of prescription drug prices on the Massachusetts health care market. The HPC's current authority is limited to drugs referred by the Executive Office of Health and Human Services. While this authority will help address cost concerns in the Medicaid space, there is no guarantee that the review undertaken by the HPC will translate to the commercial space.

Equally important is the requirement that drug manufacturers and PBMs be part of the annual cost trends hearing. This is vital to understand the impact pharmaceutical pricing plays on the statewide cost benchmark, whether the costs associated with therapies offer value in comparison to other therapies and treatments, and if they are improving patient care. Over the past several years, the continued lack of accountability for the pharmaceutical industry has resulted in unchecked pricing growth impacting health plans, employers, and consumers.

In the same vein, accountability for hospital systems has been limited by the parameters of the Performance Improvement Plan (PIP) process. Today, the PIP process is a powerful tool that the Commission can use to hold **individual entities** accountable by creating an incentive to limit spending growth. As the HPC noted in its presentation at the Benchmark Hearing, the PIP process has garnered significant insight for the HPC into market trends and entities' cost control strategies, and even without a PIP being required, entities may make certain cost containment commitments as part of the review process.

However, the scope of referable entities for the PIP process is limited to health plans and primary care provider groups. It does not include entities like pharmaceutical manufacturers or hospitals, which limits the ability of the PIP process to hold all entities accountable. We urge the Commission to consider the importance of full-system accountability in light of continued increases in hospital inpatient and outpatient spending. It is time for the entire system to be held accountable to the cost growth benchmark.

Addressing Provider Prices: Price Variation, Facility Fees, Urgent Care Centers and Surprise Billing

Price Variation

Over the past decade, over 30 state reports have examined health care costs and the key cost drivers in the Commonwealth. Each and every report has found that **the prices charged by providers remain the most significant factor driving health care costs.** Since 2001, price, rather than utilization, has been identified as a primary driver of health care spending, and CHIA estimates that approximately 50% of spending growth in Massachusetts is typically explained by growth in unit prices. Price accounted for 59%, 100%, and 57% of cost growth for the state's three largest health plans from 2015 to 2017. [5]

As the Commission's *2019 Cost Trends Report* notes, "total health care spending is a function of the prices of health care services as well as health care utilization." However, the Commission has identified some concerning trends associated with prices and utilization in the hospital inpatient and

[5] https://www.mass.gov/news/special-commission-on-provider-price-variation-report

outpatient space. In the commercial inpatient market in Massachusetts, hospital inpatient spending has continued to grow despite a constant or declining number of hospital stays. Commercial inpatient utilization actually declined by 9.3% between 2014 and 2018, while spending, associated with higher prices charged, continued to grow by 5.2%.

As volume shifts from hospital inpatient to hospital outpatient care, stakeholders expect savings associated with lower-cost sites of care. However, the Commission notes that hospital outpatient spending has grown quickly in the commercial market, increasing by $700 million between 2015 and 2018 to account for 31% of all commercial spending growth. Increases in instances of outpatient surgery have driven spending growth in this category; however, any potential cost savings have been mitigated by a shift to higher-cost outpatient centers as there is considerable variation in average payments for hospital outpatient surgeries, with the highest priced hospital systems garnering payments between 40% and 78% above the median. These trends are especially concerning as high-priced hospital systems continue to expand outside of the Boston area, building outpatient, urgent care, and ancillary facilities to serve patients directly in the community.

These expansions have fallen outside of the purview of the Commission's Material Change Notice and Cost and Market Impact Review process; however, they will have a significant impact on the state's ability to meet the health care cost growth benchmark. As the Commission considers provider performance against the benchmark, it will be important to pay special attention to these transactions, including how the actual results align with the anticipated benefits providers articulate in their Determination of Need requests to the Department of Public Health, whether they have leveraged higher prices as a result of these transactions, and what impact the expansions of higher priced hospital systems into the community are having on the state's ability to meet the benchmark.

We also strongly support the HPC's recommendation from the *2019 Cost Trends Report* that the state closely scrutinize how care is delivered and paid for in ambulatory settings. It is vital that the state understand the impact of outpatient service expansions and the shift of patient care to outpatient settings.

Facility Fees

As care shifts to outpatient settings, consumers are facing inappropriate and often unexpected bills for "facility fees." Facility fees were originally established to offset costs shared by outpatient facilities on hospital campuses for shared facility maintenance. Today, facilities many miles away from the hospital campus use facility fees as a source of additional revenue; the Provider Price Variation Commission noted that these fees generate billions of dollars in annual revenue for hospitals at a cost to consumers.[6] As such, we strongly support the HPC's recommendation to limit facility fees. We urge the Commission to consider a clear prohibition on hospitals, health systems, and hospital-based facilities for charging facility fees rendered in a facility located away from the main campus and for certain services regardless of location as part of its future recommendations, and encourage an examination of the impact of facility fees on the state's ability to meet the benchmark.

Urgent Care Centers

In addition to care shifting from hospital inpatient to hospital outpatient settings, we are also seeing an increase in the availability and utilization of urgent care centers. Between 2010 and 2018, the

[6] https://www.mass.gov/news/special-commission-on-provider-price-variation-report

number of urgent care centers increased by 700% across Massachusetts.[7] As the proliferation of urgent care centers continues to grow, separate licensure for urgent care centers is necessary so that consumers know what to expect if seeking care at an urgent care center and understand the cost-sharing associated with a visit. Ambiguity in current state regulation has led some consumers to seek urgent care services at facilities that bill as outpatient centers, causing additional cost-sharing for consumers. In order to truly understand the impact of health care spending at urgent care centers, it is essential that the state establish a clear and distinct definition of urgent care clinic for licensure purposes.

Surprise Billing

Legislative efforts to address unexpected out-of-network (OON) billing by providers have great potential to lower health care spending on OON care; however, in order to realize savings, such measures must include a default rate appropriate for the service rendered, high enough to adequately reimburse the provider, and low enough to encourage provider participation in health plan networks. Today, 85% of all OON physician claims originate from ERAP providers – emergency room physicians, radiologists, anesthesiologists, and pathologists – with average spending on OON claims far exceeding the average in-network spending. OON billing increases costs for employers and consumers and threatens the state's ability to meet the cost growth benchmark. Therefore, we strongly support the HPC's recommendation that the legislature "enact a comprehensive law to address out-of-network billing" and to "[set] a reasonable and fair reimbursement rate for out-of-network services through a statutory or regulatory process… [that] avoids using provider charges or list prices as benchmarks in determining payment." As the Commission considers performance against the benchmark, we recommend the continued practice of OON billing be monitored and assessed.

MAHP and our member plans are committed to ensuring access to high-quality, affordable health care services. The health care cost growth benchmark is an important tool in holding all entities accountable for health care costs in the Commonwealth. We appreciate the opportunity to offer these comments as you consider the 2021 benchmark. Please feel free to contact me directly should you have any questions or need additional information on our comments.

Sincerely,

Lora Pellegrini
President & CEO, Massachusetts Association of Health Plans

Cc: Secretary Marylou Sudders, M.S.W, Executive Office of Health and Human Services
Secretary Michael J. Heffernan, Executive Office of Administration and Finance
Stuart Altman, Ph.D. Health Policy Commission Chair
Martin Cohen, Health Policy Commission Vice Chair
Barbara Blakeney, MS, RN, FNAP, Committee Chair, Care Delivery Transformation
David Cutler, Ph.D., Committee Chair, Market Oversight and Transparency

[7] https://www.mass.gov/info-details/hpc-datapoints-issue-8-urgent-care-centers-and-retail-clinics

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